Consensus Elements for a Reconfigured Futures Plan

Working Format for
VSH Futures Advisory Committee
February 24, 2006

Vermont State Hospital Futures Plan: Report to Secretary Charles Smith: February 4th 2005

"We, Vermonters, hold a broad common vision regarding mental health care: we expect services to be of high quality and to be provided in a holistic, comprehensive continuum of care, where consumers are treated at all times with dignity and respect, where individual rights are protected, where public resources are allocated efficiently and produce the best positive outcomes, and where direct services overseen and provided by the Agency of Human Services and its community partners are person- and family-centered and driven, are accessible, and are culturally competent. We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary."

From Secretary Charlie Smith Recommendations to the Vermont Legislature: February 4th, 2005 Recommendations for the Future of Services Provided at the Vermont State Hospital; Strengthening the Continuum of Care for Vermonters with Mental Illness

Pursuant to Sec 141(a) and (b) of the Appropriations Act for 2005, I am pleased to offer a plan for the future delivery of in-patient services that are currently provided at the Vermont State Hospital (VSH). In addition, I am pleased to offer recommendations to strengthen the entire service system for Vermonters with mental illness and substance abuse disorders, and to ensure that the recommendations of the corrections mental health service plan are coordinated with and complementary to my recommendations for the continuum of care. Also included, as directed in the statute, are timelines and operating cost estimates.

Vermont law directs that it be our policy "to work towards a mental health system that does not require coercion or the use of involuntary medication."[1] In light of this policy, at every point in our planning process, we should be seeking ways to reinforce a system that maximizes reasonable choices of voluntary services and avoids or minimizes involuntary treatment. While acknowledging that court ordered or involuntary care is sometimes required, we ask that these recommendations be read with this policy in mind.

It is also clear that services are not well coordinated across the continuum of mental health care, from primary care providers to the community partners, to the designated hospitals, to the VSH and prisons; that many services, especially in the adult out-patient and substance abuse categories, are bottle-necked at the community level; that opportunities for effective early intervention are being missed; and that many Vermonters

[1] 18 V.S.A. § 7629(c).

in need are not receiving services. Further, it is clear that the community mental health system has faced increasing demands for service, with limited funds allocated for cost of living and inflationary pressures.

This plan, fully implemented, would transform in-patient and rehabilitation services for the most severely ill. It would improve coordination of services and increase capacity for all adults with mental health problems. The result would be a continuum in which all of the elements are coordinated; in which prevention, early intervention and alternatives to hospitalization are pursued aggressively; in which peer supports are expanded and fully respected as essential to recovery; in which the individual is actively engaged in the development of his or her treatment plan; and in which outcomes are measured and continuous improvement is a key goal.

VSH Futures Advisory Committee Recommendations to Secretary Mike Smith: November 16th, 2005

The VSH Futures Advisory Committee offers the following recommendations about the sustainability of the MH Services System, the selection criteria for the inpatient service sites and partners, and the scope of the needed services infrastructure to successfully implement the Futures Plan.

"Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers."

"The VSH Futures Advisory Committee notes that its "support in concept" for the overall Futures plan, and its formal votes regarding advancing specific components, all remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that, in significant part based on prior direct experience, a replacement inpatient unit alone with or without the addition of sub acute beds can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services, including designated inpatient programs, and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the time line that targets a new inpatient facility opening in June, 2010; and that any expedited time line would also expedite the associated program components in the budget."

Selection Criteria for the Primary Inpatient Site[2]

1. The primary VSH replacement service should not be an IMD
2. It should be attached to or near (in sight of) a tertiary / teaching hospital
3. Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
4. There must be adequate space to develop or renovate a facility that will accommodate census needs.
5. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.
6. Costs - both ongoing operations and capital construction - should be considered.
7. Outdoor activity space should be readily accessible to the units.
8. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.
9. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.
10. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.
11. Willingness to participate in a public reporting of common quality standards is required.
12. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.
13. Ability to collaborate with neighbors.
14. Ability to work closely with state and designated agency partners
15. The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.

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[2] The selection criteria for the smaller inpatient capacities are very similar to those of the primary site-exceptions are: preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners; A location consideration is to assure adequate distribution of services throughout the state; and the ability to provide adequate on-site medical care and demonstrated access to hospital medical services.